STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	901 COUNTY FARM RD MURFREESBORO, TN 37127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to protect the smoke barriers as required. The findings include: On 6/6/11 at 3:20 P.M. observation within resident room # F-2 revealed there was a penetration in the corridor side wall of the bathroom. This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/6/11.	K 025	A. The penetration identified was sealed by the Maintenance Department on 6/6/2011 to prevent the passage of smoke. B. All other corridor walls in resident rooms have the potential of being affected with penetrations. An audit of all corridor walls was completed on 6/21/2011 by the Maintenance Department. There were two (2) other penetrations similar to the one found. Areas were repaired to prevent the passage of smoke and documented on 6/21/2011. C. Resident bathrooms will be inspected as part of monthly Preventative Maintenance checks. Maintenance staff will be inserviced on sealing any penetrations after all work is complete. That inservice was completed on 6/22/2011. D. Maintenance Director will report monthly audit findings to the Quality Assurance Committee until 100% compliance has been maintained for three consecutive (3) months and will report as needed thereafter.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Charles M Key — Administrator — 6/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.